APPENDIX R-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM HFS 2212, HOME HEALTH INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script or any font that has connecting characters.
- Claims should be typed or computer printed in capital letters. The character pitch must be 10-12 printed characters per inch, the size of most standard Pica or Elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photocopying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

A sample of Form HFS 2212 (Health Agency Invoice) may be found on the Department's Web site at: <http://www.hfs.illinois.gov/medicalforms/>. Instructions for completion of this invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of provider services.

COMPLETION	**ITEM EXPLANATION AND INSTRUCTIONS**
Required	**1. Provider Name** – Enter the provider's name exactly as it appears on the Provider Information Sheet.
=Required	**2. Provider Number** – Enter the NPI number.
Required	**3. Payee** – Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.
Not Required	4. Group – Leave blank.
Not Required	5. Role – Leave blank.

Conditionally Required

6. Acc/Inj – When applicable enter one of the following codes to indicate the probable reason participant sought treatment:

1 – Employment related accident or illness
2 – Injury received while operating a motor vehicle, as a passenger in a motor vehicle, or in another type of accident involving a motor vehicle
3 – Injury due to participation in an organized sport or school activity
4 – Injury due to an act of violence (non-accidental)
5 – Injury is the result of an unspecified accident

Optional

7. Provider Reference – Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider.

Optional

8. Provider Street – Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If address is not entered, the Department will not attempt corrections.

Conditionally Required

9. Facility & City Where Service Rendered – This entry is required when Place of Service Code is other than K (patient's home).

Conditionally Required

10. Prior Approval – This entry is required for services provided within 60 days of an inpatient hospital discharge. The patient's hospital discharge date (MMDDYYYY format) is the required entry.
For services, which require prior approval leave this field blank. Refer to Topic R-211, Prior Approval Process for more information.

Optional

11. Provider City State Zip – Enter city, state and zip code of provider. See item 8 above.

Required

12. Referring Practitioner Name – Name of referring physician.

=Required

13. Ref. Prac. No. – Enter the referring physician's NPI.

Required

14. Recipient Name – Enter the patient's name exactly as it appears on the Medical Programs Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field.

Required

15. Recipient No. – Enter the nine-digit number assigned to the individual as copied from the Medical Programs Card. Do not use the Case Identification Number.

If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birth date on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.

Conditionally Required

16. Birth date – Enter the month, day and year of birth of the patient as shown on the Medical Programs Card. Use the MMDDYY format.

Not Required

17. Healthy Kids – Leave blank.

Not Required

18. Fam Plan – Leave blank.

Not Required

19. Cr. Child – Leave blank.

Not Required

20. St/Ab – Leave blank.

Required

21. Billing Date – Enter the date the invoice was prepared. Use the MMDDYY format.

Required

22. Primary Diagnosis – Enter the diagnosis description from ICD-9-CM, which describes the condition primarily responsible for the patient's treatment.

Conditionally Required

23. Prefix – When the ICD-9-CM diagnosis code has an alphabetic prefix of E or V, enter it here.

Required

24. Diag. Code – Enter the ICD-9-CM code for the primary diagnosis described in Item 22. All characters to the left of the decimal point should be entered to the left of the dividing line.

All characters to the right of the decimal point should be entered to the right of the dividing line.

EXAMPLE: 030.3 030 | 3

Conditionally Required

25. Secondary Diagnosis – When treatment is the result of dissimilar conditions, the diagnosis description from ICD-9-CM for the secondary diagnosis is entered.

Conditionally Required

26. Prefix – When the ICD-9-CM secondary diagnosis code has an alphabetic prefix of E or V, enter it here. This entry is required only if a secondary diagnosis is entered.

Conditionally Required

27. Diag. Code – Enter the ICD-9-CM code for the secondary diagnosis described in Item 25.

=

28. Service Sections
Intermittent Services – Complete one service section for each item or service provided to the patient.
In-home Shift Nursing – Complete one service section for each week of services being billed for the patient. Bill at the end of the week after the services have been rendered.

=Required

A. Procedure Description
Intermittent Services – Enter the appropriate description of the service provided.
In-home Shift Nursing – Enter the description for procedure code G0154 – services of skilled nurse in home health setting, each 15 minutes or G0156 – services of home health aide in home health setting, each 15 minutes. Although these codes are defined as “each 15 minutes," reimbursement will be per hour.

=Required

B. Proc. Code
Intermittent Services – Enter the appropriate five-digit procedure code, which can be found, on your Provider Information Sheet. Report the 2-byte modifier immediately following the procedure code.
Modifier U2 – Skilled Nursing Assessment Visit is used to designate an initial home nursing assessment visit.
In-home Shift Nursing – Enter procedure code G0154 or G0156.

Conditionally Required

C. Delete – When an error has been made that cannot be corrected, enter an “X” to delete the entire service section. Only “X” will be recognized as a valid character; all others will be ignored.

=Required

D. Date of Service
Intermittent Services – Enter the date the service was performed. Use MMDDYY format.
In-home Shift Nursing – Enter the last date for the week that you are billing. For example, if the week is January 21, 2008, through January 27, 2008, enter 012708.

Required

E. Cat. Serv. – Enter the two-digit code, which identifies the service provided. Valid codes are:
66 – Home Health Services

=Required

F. Place of Serv.
Intermittent Services – Enter the one letter Place of Service Code from the following list:

Code:	**Place of Service:**
H	Long Term Care Facility
I	Shelter Care
K	Patient's Home

In-home Shift Nursing – Enter "K" for patient's home.

=Required

G. Units
Intermittent Services – Enter the number of visits per day.
In-home Shift Nursing – Enter "1" for one week.

Not Required

H. Shaded Field – Leave Blank.

Conditionally Required

I. TPL Code – If the patient's Medical Programs Card contains a TPL code, the numeric three-digit code must be entered in this field. If there is no TPL resource shown on the card, no entry is required.

When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form HFS 2432 shows a recipient liability greater than $0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	the actual recipient liability as shown on Form HFS 2432
TPL Date	the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

If Form HFS 2432 shows a recipient liability of $0.00, the invoice should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	the issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

Conditionally Required

J. Status – If a TPL code is shown in item I, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 – TPL Adjudicated – spenddown met: TPL Status Code 04 is to be entered when the patient's Form HFS 2432 shows $0.00 liability.

05 – Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 – Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 – Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

Conditionally Required

K. TPL Amount – If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For status codes 02-10, enter 0 00.

Conditionally Required

L. Adjudication Date – A TPL date is required when any status code is shown in Item 28I. Use the date specified below for the applicable code:

Code	Date to be entered
01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

=Required

M. Provider Charge

Intermittent Services – Enter the total charge for the service, not deducting any TPL.

In-home Shift Nursing – Enter the total weekly charge approved by the Department for the level of service provided. If fewer hours of care were provided during the week than the number allowed, bill charges for the actual number of hours used.

For example: 20 hours of RN service at the hourly RN rate
25 hours of LPN service at the hourly LPN rate
6 hours of CNA service at the hourly CNA rate

The following is a sample calculation of the amount to be entered in field M. The rates shown are not indicative of actual rates.

20 hours of RN service at $15 per hour = $300
25 hours of LPN service at $10 per hour = $250
6 hours of CNA service at $7 per hour = $ 42
Total charges to be entered in field M. $592

Conditionally Required

N. Repeat – Place X if the service is done on the next date.

Not Required

29. Shaded Area – Leave blank.

30. Charges and Deductions Section – The information field in the lower right of the HFS 2212 is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources 2) to identify uncoded TPL carriers by name and 3) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in Service Sections 1 through 7 of the HFS 2212, complete the TPL fields in accordance with the following instructions:

Conditionally Required

Sect. # – If more than one third party made a payment for a particular service, enter the service section number (1 through 7) in which that service is reported.

If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in this section will be applied to the total of all service sections on the invoice.

Conditionally Required **TPL Code** – Enter the appropriate TPL Resource Code referencing the source of payment (General Appendix 9). If the TPL Resource Codes are not appropriate enter 999 and enter the name of the payment source in the Uncoded TPL Name field.

Conditionally Required **Status** – Enter the appropriate TPL Status Code. See Item 28J in this Appendix for correct coding of this field.

Conditionally Required **TPL Amount** – Enter the amount of payment received from the third party resource.

Conditionally Required **Adjudication Date** – Enter the date the claim was adjudicated by the third party resource. (See Item 28L in this Appendix for correct coding of this field.)

Conditionally Required **Uncoded TPL Name** – Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

The three claim summary fields must be completed on all Invoices. These fields are Total Charges, Total Deductions and Net Charge. They are located at the bottom right of the form.

Required **Total Charge** – Enter the sum of all charges submitted on the Invoice in service Sections 1 through 7.

Required **Total Deductions** – Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (0 00).

Required **Net Charge** – Enter the difference between Total Charge and Total Deductions fields.

Required **31. # Sects** – Enter the total number of service sections completed correctly in the top part of the form. This entry must be at least one and not more than 7. Do not count any sections that were deleted.

Not Required 32. Original DCN – leave blank.

Not Required 33. Original Voucher Number – leave blank.

Required **Provider Certification, Signature and Date** – After reading the certification statement, the provider or an authorized representative must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Unsigned Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Health Agency Invoice is a two-part form. The provider is to submit the original to the Department as indicated below. The pin-feed guide strip should be detached from the sides of continuous feed forms. The copy of the claim is to be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 2246, Health Agency Invoice Envelope, provided by the Department.

Non-routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1414, Special Handling Envelope, which is provided by the Department for this purpose. A non-routine claim is one to which one or more of the following documents are attached:

Form HFS 1411, Temporary MediPlan Card
Any other document

Forms Requisition - Billing forms may be requested on our Web site at http://www.hfs.illinois.gov/forms/ or by submitting an HFS 1517 or HFS 1517A as explained in Chapter 100, General Appendix 10.

APPENDIX R-2

PREPARATION AND MAILING INSTRUCTIONS FOR FORM HFS 1409, PRIOR APPROVAL REQUEST

Form HFS 1409, Prior Approval Request, is to be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services and items requiring prior approval are identified in this handbook.

Form HFS 1409 is a multi-part form. A sample of Form HFS 1409, Prior Approval Request may be found on the Department's Web site http://www.hfs.illinois.gov/medicalforms/

INSTRUCTIONS FOR COMPLETION

The form is to be typewritten or legibly hand printed. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional – In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of provider services.

COMPLETION	**ITEM EXPLANATION AND INSTRUCTIONS**
Not Required	Document Control Number – leave blank
Not Required	1. Trans Code (Transaction Code) – Leave blank
Not Required	2. Prior Approval Number – Leave Blank
Not Required	3. Case Name – Leave Blank.
Required	**4. Recipient Name** – Enter the name of the patient for whom the service or item is requested.

Required

5. Recipient Number – Enter the nine-digit recipient number assigned to the patient for whom the service or item is requested. This number is found to the right of the patient's name on the back of the Medical Programs Card.

Required

6. Birth date – Enter the patient's birth date. This is a six-digit field. Entry must be in MMDDYY format, with no commas or dashes. For example, a birth date of February 3, 1995, would be entered as 020395.

Conditionally Required

7. Inst Set (Institutional Setting) – An entry in this field is required only when the patient resides in a long term care facility.

Enter one of the following codes to identify the arrangement:
H = Long Term Care Facility
I = Sheltered Care Facility

Not Required

8. Case Identification Number – Leave blank.

Required

9. Recipient Street Address – Enter the patient's current street address. The Department will use this information to mail the patient the "Notice of Decision on Request for Medical Service/Item."

Conditionally Required

10. Facility Name – An entry in this field is required only when an entry appears in Item 7 above.

Required

11. Recipient City – Refer to Item 9 above.

Conditionally Required

12. Facility City – An entry in this field is required only when an entry appears in Items 7 and 10.

Required

13. Requesting Provider Name – Name of referring physician.

Required

14. Request Prov. No. – Enter a unique identifying number (provider #; SSN; UPIN) of the physician who has ordered the home health services.

Not Required

15. Provider Street Address – Leave blank.

Required

16. Provider Telephone – Enter the telephone number of the provider's office.

Not Required

17. Provider City, State, Zip – Leave blank.

Required

18. Supplying Provider Name – Enter the name of the provider who will provide the service or item.

Required **19. Supply Prov No (Supplying Provider Number)** – Enter the supplying provider's Provider Number exactly as shown on the Provider Information Sheet.

Required **20. Provider Street** – Enter the provider's address. This information will be used to return a copy of the processed (approved/denied) request.

Required **21. Provider Telephone** – Enter the telephone number of the provider's office. This information is helpful in instances where the Department needs additional information in order to act upon the request.

Required **22. Provider City, State, Zip** – Refer to entry field 20.

23 – 26 Leave blank.

27. Service Sections – The form provides space to request a maximum of three services/items. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:

=Required **Req. Proc. Code (Requested Procedure Code)**
Intermittent Services – Enter the appropriate five-digit procedure code, which can be found, on your Provider Information Sheet.
In-home Shift Nursing – Enter procedure code G0154 or G0156.

Required **Req Qty (Requested Quantity)** – Enter the number of items or the number of times the service is to be performed.

Required **Prov Charge (Provider Charge)** – Enter the provider's charge for the service(s).

Required **Cat Serv (Category of Service)** – Enter the two-digit code 66 – Home Health Services

=Required **Description** – Specify if services requested are either intermittent visits or hourly in-home shift nursing. The provider's workweek must be indicated for in-home shift nursing. If additional space is needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.

Required **28. Medical Necessity** – The provider is to enter a statement as to the need for the service(s) requested. If additional space is needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.

Required **29. Supplying Provider Signature** – The form is to be signed in ink by the individual who is to provide the service.

Required **31. Request Date** – Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. The top, signed copy of the request is to be mailed to:

Illinois Department of Healthcare and Family Services
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124

The remaining copies may be retained in the provider's records.

A notification of approval or denial of the service(s) will be mailed to the provider and patient.

APPENDIX R-3

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign and date your signature on the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic R-201.2 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix R-3a. The item numbers that correspond to the explanations below appear in small circles ◯ on the sample form.

FIELD	EXPLANATION
(1) **Provider Key**	This number uniquely identifies the provider and is used internally by the Department. It is directly linked to the reported NPI shown in field 9.
(2) **Provider Name And Location**	This area contains the **Name and Address** of the provider as carried in the Department's records. The three-digit **County** code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The **Telephone Number** is the primary telephone number of the provider's primary office.
(3) **Enrollment Specifics**	This area contains basic information concerning the provider's enrollment with the Department. **Provider Type** is a three-digit code and corresponding narrative, which indicates the provider's classification.

Organization Type is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice
02 = Partnership
03 = Corporation
04 = Group Practice

Enrollment Status is a one-digit code and corresponding narrative, which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active
I = Inactive
N = Non Participating

Disregard the term MOCST if it appears in this term.

Immediately following the enrollment status indicator are the **Begin** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **End** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **End** date field.

Exception Indicator may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested by Audits
C = Citation to Discover Assets
G = Garnishment
S = Exception Requested by Provider Participation Unit
T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **Exception Indicator** are the **Begin** date indicating the first date when the provider's claims are to be manually reviewed and the **End** date indicating the last date the provider's claims are to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form HFS 1413 (Provider Agreement) on file. If the value of the field is yes, the provider is eligible to submit claims electronically.

4 **Certification/ License Number**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **Ending** date indicating when the license will expire.

5 **S.S.#**

This is the provider's Social Security or FEIN number.

6 **Categories of Service**

This area identifies special licensure information and the types of service a provider is enrolled to provide.

Eligibility Category of Service contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The code is:

066 – Home Health Services

Each entry is followed by the date that the provider was approved to render services for each category listed.

7 **Payee Information**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **Payee Code,** which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

Payee ID Number is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

The **Medicare/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

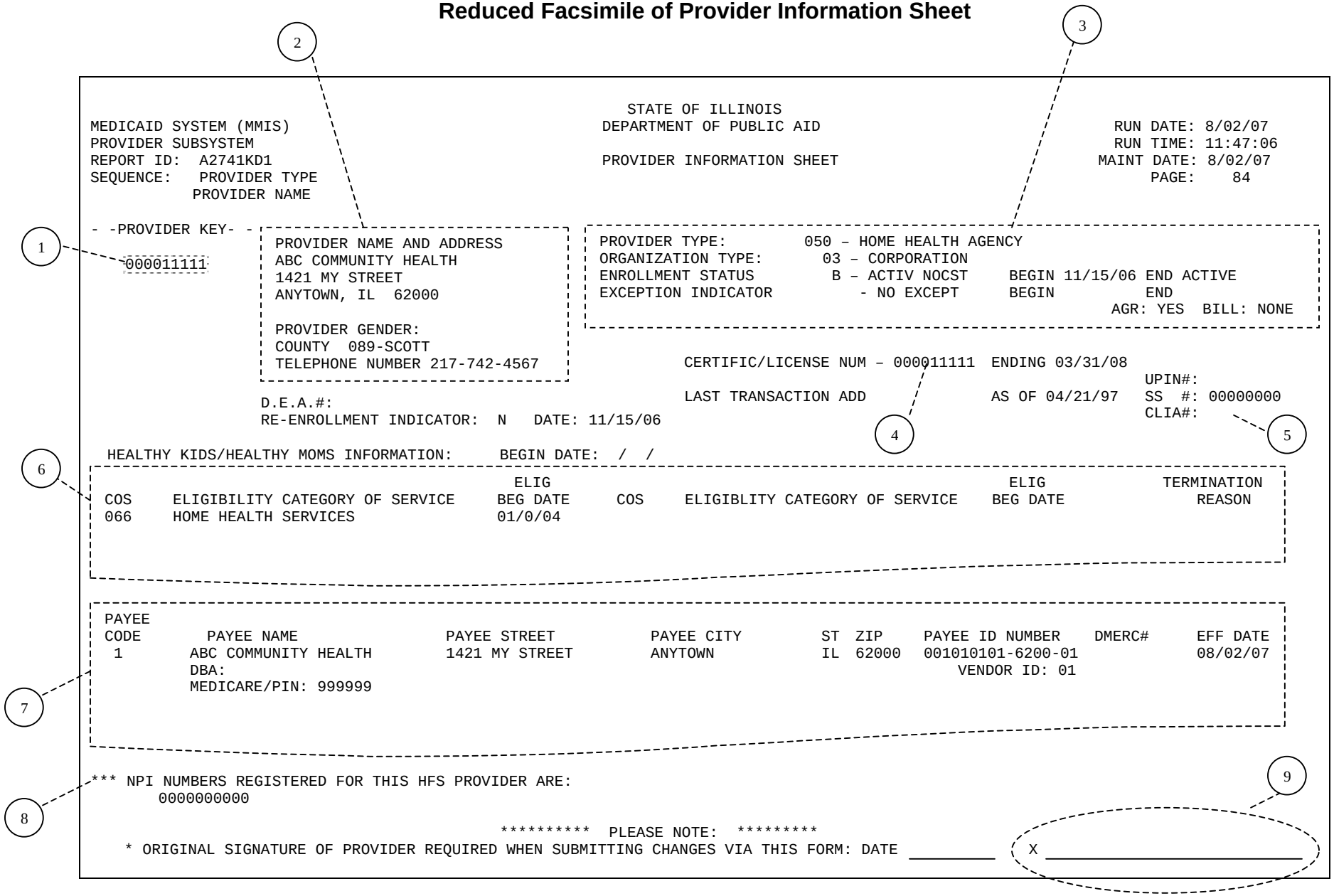
8 **NPI**

The National Provider Identification Number contained in the Department's provider database.

9 **SIGNATURE**

The provider is required to affix an original signature when submitting charges to the Department of Healthcare and Family Services.

APPENDIX R-3a
Reduced Facsimile of Provider Information Sheet



```
                                   STATE OF ILLINOIS
MEDICAID SYSTEM (MMIS)             DEPARTMENT OF PUBLIC AID                RUN DATE: 8/02/07
PROVIDER SUBSYSTEM                                                         RUN TIME: 11:47:06
REPORT ID:  A2741KD1               PROVIDER INFORMATION SHEET            MAINT DATE: 8/02/07
SEQUENCE:   PROVIDER TYPE                                                       PAGE:    84
          PROVIDER NAME

- -PROVIDER KEY- -
                                   PROVIDER NAME AND ADDRESS
    000011111                      ABC COMMUNITY HEALTH
                                   1421 MY STREET
                                   ANYTOWN, IL  62000

                                   PROVIDER GENDER:
                                   COUNTY  089-SCOTT
                                   TELEPHONE NUMBER 217-742-4567

                                   D.E.A.#:
                                   RE-ENROLLMENT INDICATOR:  N   DATE: 11/15/06

PROVIDER TYPE:         050 – HOME HEALTH AGENCY
ORGANIZATION TYPE:       03 – CORPORATION
ENROLLMENT STATUS         B – ACTIV NOCST     BEGIN 11/15/06 END ACTIVE
EXCEPTION INDICATOR          - NO EXCEPT      BEGIN          END
                                                          AGR: YES  BILL: NONE

CERTIFIC/LICENSE NUM – 000011111  ENDING 03/31/08
                                                          UPIN#:
LAST TRANSACTION ADD              AS OF 04/21/97          SS  #: 00000000
                                                          CLIA#:

HEALTHY KIDS/HEALTHY MOMS INFORMATION:     BEGIN DATE:  /  /

                                        ELIG                                          ELIG          TERMINATION
COS    ELIGIBILITY CATEGORY OF SERVICE  BEG DATE   COS   ELIGIBLITY CATEGORY OF SERVICE  BEG DATE        REASON
066    HOME HEALTH SERVICES             01/0/04

PAYEE
CODE      PAYEE NAME              PAYEE STREET        PAYEE CITY      ST  ZIP    PAYEE ID NUMBER    DMERC#    EFF DATE
 1        ABC COMMUNITY HEALTH    1421 MY STREET      ANYTOWN         IL  62000  001010101-6200-01             08/02/07
          DBA:                                                                      VENDOR ID: 01
          MEDICARE/PIN: 999999

*** NPI NUMBERS REGISTERED FOR THIS HFS PROVIDER ARE:
      0000000000

                                  **********  PLEASE NOTE:  *********
   * ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE _____  X _____
```